

CERTIFICATION OF SPECIALIZED PROGRAMS APPLICATION FOR CERTIFICATION

Michigan Department of Human Services
Bureau of Children and Adult Licensing

FOR DHS USE ONLY – Cashier code: 41

License Number:

Paid Amount:

Cashier:

SECTION I – FACILITY INFORMATION

1. Type of Application: <input type="checkbox"/> INITIAL <input type="checkbox"/> MODIFICATION: Specify Change _____ Effective Date of Change _____					
2. Certificate Type (Population served must be mentally ill and/or developmentally disable as authorized by AFC License.) <input type="checkbox"/> MENTAL ILLNESS <input type="checkbox"/> DEVELOPMENTAL DISABILITY <input type="checkbox"/> MENTAL ILLNESS & DEVELOPMENTAL DISABILITY					
3. Facility Name		4. Facility Street Address		5. Facility City, State, Zip	
6. Area Code/Telephone Number		7. Area Code/Fax Number		8. Email Address (if applicable)	
9. Facility Mailing Address (if different than #4)			10. County		11. Township
12. AFC License Number		13. AFC Expiration Date		14. Licensed Capacity	
				15. Current Occupancy	
16. Number of individuals residing in the facility for whom you receive specialized compensation. Persons with Mental Illness _____ Persons with Developmental Disability(ies) _____ Persons with Mental Illness and Developmental Disability(ies) _____					

SECTION II – ADULT FOSTER CARE LICENSEE INFORMATION

17. Name of Licensee		18. Licensee Designee (if applicable)	
19. Street Address		20. City, State, Zip Code	
		21. Mailing Address (if different than #19)	
22. Area Code/Telephone Number		23. Area Code/Fax Number	
		24. Email Address	

SECTION III – PLACING AGENCY INFORMATION (Attach additional sheets as necessary)

25. Agency Name		26. Contact Person	
27. Street Address		28. City, State, Zip Code	
		29. Mailing Address (if different than #27)	
30. Area Code/Telephone Number		31. Area Code/Fax Number	
		32. Email Address	

SECTION IV – STAFFING INFORMATION

33. Staff-to-resident ratio on each shift: A.M. Shift: _____ P.M. Shift: _____ MIDNIGHT Shift: _____			
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SECTION V – DESCRIPTION OF SPECIALIZED PROGRAM(S) PROVIDED

34. Specialized Program Description (Attach additional sheets if necessary)

SECTION VI – CERTIFICATION AND SIGNATURE

The applicant certifies that the relevant provisions of 1974 PA 258, as amended (Mental Health Code), the Administrative Rules (330.1801 through 330.1809), and relevant portions of the 1985 Life Safety Code, Appendix F, which regulate the operation of Specialized Programs Offered to Persons with Mental Illness or Developmental Disability(ies) have been read.

The applicant certifies that the information contained in this application is true, complete and accurate to the best of the applicant's knowledge.

35. Adult Foster Care Licensee Name (print or type)	36. Licensee or Licensee Designee Signature	37. Date Signed
Authority: 1979 PA 218 1974 PA 258 Completion: Mandatory Penalty: Certification will not be issued.	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.	